



Utah Department of Health  
Office of Primary Care and Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
Web Site: <http://health.utah.gov/primarycare/>

**UTAH HEALTH CARE WORKFORCE  
FINANCIAL ASSISTANCE PROGRAM**  
**ATTENTION: Nursing Schools/Training Institutions**  
**Site Applications Are Reviewed Twice A Year**

Page 1 of 7

**UTAH NURSING SCHOOL/TRAINING INSTITUTION  
SITE APPLICATION FORM**

**REQUIRED INFORMATION**

To become an eligible site for the Utah Health Care Workforce Financial Assistance Program (HCWFAP), the applicant Utah Nursing School/Training Institution must complete the **entire** "Site Application Form" and include all requested attachments. **All of the required information and documentation must be submitted in a single package.** The information contained in the Site Application Form will be used to assist in determining eligibility and prioritization of sites. Section A through E are not scored, but answers are required.

A. \_\_\_\_\_  
Name of Nurse Training Program (*must be actual location Nursing Educator/Instructor will be Instructing At*)

\_\_\_\_\_  
Name of School/Educational Institution

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Mailing Address (if different than Street Address)

\_\_\_\_\_  
County Site Located In

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip Code

( ) \_\_\_\_\_  
Telephone Number

( ) \_\_\_\_\_  
Fax Number

B. \_\_\_\_\_  
Name of Sponsoring Organization (If different than School/Educational Institution)

\_\_\_\_\_  
Name and Title of Sponsoring Administrative Official

X \_\_\_\_\_  
*Signature of Sponsoring Administrative Official*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Mailing Address (if different than Street Address)

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip Code

( ) \_\_\_\_\_  
Telephone Number

( ) \_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Web Site Address

<http://> \_\_\_\_\_

**PLEASE TYPE OR PRINT LEGIBLY**

**NOTE: Only Utah Nursing Schools/Training Institutions are Eligible for This Program.**

F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Site\HCWF Nurse Educator siteapplication 01-03.wpd 04-14-2004



Utah Department of Health  
Office of Primary Care and Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
Web Site: <http://health.utah.gov/primarycare/>

**UTAH HEALTH CARE WORKFORCE  
FINANCIAL ASSISTANCE PROGRAM**  
**ATTENTION: Nursing Schools/Training Institutions**  
**Site Applications Are Reviewed Twice A Year**

Page 2 of 7

- C. Check Only One Below: Check Only One As Follows:
- |  |   |
|--|---|
| <input type="checkbox"/> Public                        | <input type="checkbox"/> Institution        |
| <input type="checkbox"/> Private Non-Profit            | <input type="checkbox"/> College/University |
| <input type="checkbox"/> Private For-Profit            |   |
| <input type="checkbox"/> Other (please explain): _____ |   |
- D. **Health Care Professionals covered by the HCWFAP.**
1. Please note that ***only the following*** fully-licensed health care professionals are covered by the HCWFAP:
- Nurse Educators/Instructors:  
Master's Degree Nurse (M.S.N.)  
Doctorate of Philosophy in Nursing (Ph.D.)
- E. **Scored Section of Site Application.** Responses are required for all questions. Please write "NA" or detailed explanation to questions that are not applicable to your nursing school/training institution.
- F. **Specialty, education level, setting; percent and/or FTE; and length of time vacancy has been unfilled for the Nursing Educator(s)/Instructor(s) requested.**
1. Describe the specialty, educational level, and setting of the Nursing Educator/Instructor you are requesting. (i.e., community health nurse prepared at the master's level to instruct bachelor level nursing students, etc.) **[Answer required]**
- |   |   |
|---|---|
| <input type="checkbox"/> Master's Degree in Nursing | <input type="checkbox"/> Doctorate of Philosophy in Nursing |
|---|---|
2. Include the percent and/or FTE for the position(s) requested, and the number of hours per week required for that percent/FTE. (Such as, 1 FTE or 100% master's degree nurse at 40 hours per week; .5 FTE or 50% doctor of philosophy nurse at 20 hours per week.) **[Answer required]**
3. Provide the length of time the Nursing Educator/Instructor vacancy has been unfilled. (For example, position vacant for 18 months.) **[Answer required]**

**PLEASE TYPE OR PRINT LEGIBLY**

**NOTE: Only Utah Nursing Schools/Training Institutions are Eligible for This Program.**

F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Site\HCWF Nurse Educator siteapplication 01-03.wpd 04-14-2004



Utah Department of Health  
Office of Primary Care and Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
Web Site: <http://health.utah.gov/primarycare/>

**UTAH HEALTH CARE WORKFORCE  
FINANCIAL ASSISTANCE PROGRAM**  
**ATTENTION: Nursing Schools/Training Institutions**  
**Site Applications Are Reviewed Twice A Year**

Page 3 of 7

G. **Special Qualifications of the Nursing Educator/Instructor Requested.** Describe special qualifications (if any) the Nursing Educator/Instructor may need to serve the needs at your nursing school/training institution (such as other languages, cultural experiences, specialty training, or educational level [M.S., Ph.D.]). **[Answer required]**

H. **Level of Nursing Students the Requested Nursing Educator/Instructor will be Training.** {Answer required}

- ☐ L.P.N. students
- ☐ A.D.N. students
- ☐ B.S.N. students
- ☐ M.S.N. students
- ☐ Ph.D. in nursing students

I. **Nursing Educator/Instructor Match/Need.** Do you currently have a Nursing Educator/Instructor you would like matched with your nursing school/training institution and provided financial assistance funding by the HCWFAP? If so, please provide us with the name(s) and education level(s) (such as, Florence Nightingale, M.S.N., Bacchus, Utah).

J. **Please remember, responses are required for ALL questions.** Please write detailed explanation to questions that are not applicable to your nursing school/training institution.

1. **Description of the nursing school/training institution.**

a) Please provide the total number of nursing students enrolled at the nursing school/training institution during the past school year.

Total Number of Nursing Students Enrolled	LPN	ADN	BSN	MSN	PhD
School Year:					
Number of Nursing Students Enrolled:					

b) Please provide the number of qualified nursing student applications denied by the nursing school/training institution during past school year.

Number of Nursing Student Applications Denied	LPN	ADN	BSN	MSN	PhD
School Year:					
Number of Nursing Student Applications Denied:					

PLEASE TYPE OR PRINT LEGIBLY

**NOTE: Only Utah Nursing Schools/Training Institutions are Eligible for This Program.**

F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Site\HCWF Nurse Educator siteapplication 01-03.wpd 04-14-2004



Utah Department of Health  
Office of Primary Care and Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
Web Site: <http://health.utah.gov/primarycare/>

**UTAH HEALTH CARE WORKFORCE  
FINANCIAL ASSISTANCE PROGRAM**  
**ATTENTION: Nursing Schools/Training Institutions**  
**Site Applications Are Reviewed Twice A Year**

- c) Please provide the total number of student body at the college/university during the past school year.

<b>School Year:</b>	
<b>Total Number of Students Enrolled:</b>	

2. **Residence of nursing students** (as a percent of total student body at the nursing school/training institution):

Residence of Nursing Students	Percent
Utah Residents	%
Resident of Other State	%
Resident of Other Country (Foreign)	%
Unknown	%
<b>Total</b> (Total Does Not Need To Add to 100 percent)	%

3. **Quality and adequacy of your nursing school/training institution for the requested Nurse Educator/Instructor.**  
a) Describe the nursing school/training institution, including all support services available. Provide description of the 1) physical facilities, 2) library facilities, 3) support personnel, 4) handicapped accessibility, and 5) any in-kind services for the requested Nurse Educator/Instructor. (Please assure and respond to each item listed above 1) through 5).)

- b) Provide the current **faculty to student ratio** for clinical and didactic (i.e., 1 master's level Nurse Educator/Instructor to 10 bachelor's level nursing students).

Nursing Faculty to Student Ratio				
"Clinical" Nursing Faculty		TO	Nursing Students	
Master's or Doctorate Level Nursing Educator/Instructor	_____	:	_____	Licensed Practical Level
	_____	:	_____	Associate Level
	_____	:	_____	Bachelor Level
	_____	:	_____	Masters Level
	_____	:	_____	Doctorate Level
"Didactic" Nursing Faculty		TO	Nursing Students	
Master's or Doctorate Level Nursing Educator/Instructor	_____	:	_____	Licensed Practical Level
	_____	:	_____	Associate Level
	_____	:	_____	Bachelor Level
	_____	:	_____	Masters Level
	_____	:	_____	Doctorate Level

**PLEASE TYPE OR PRINT LEGIBLY**

**NOTE: Only Utah Nursing Schools/Training Institutions are Eligible for This Program.**



4. Does the nursing school/training institution have **plans to expand enrollment**? If there are plans to expand enrollment, please provide details including dates for expansion, changes in faculty, changes in class size, and changes in enrollment.

5. **Nursing student enrollment diversity.** Special populations as a percent of total nursing student population at the nursing school/training institution where the requested Nursing Educator/Instructor would be instructing. Please note: Use "0" or NA for populations not part of nursing school/training institution.

	Percent	Source of Data
Special Needs Students ( <b>Please explain below</b> )	%	
Ethnic/Minority Students ( <b>Please describe below</b> )	%	
Other ( <b>Please describe below</b> )	%	

*Please include explanation or description of the nursing student diversity that you have included in the table above.*

6. What is your **current number** of Nursing Faculty? How many **additional** Nursing Faculty are needed?

	Number of Master's Level Faculty		Number of Doctorate of Philosophy Level Faculty	
	Full-Time	Part-Time *	Full-Time	Part-Time *
a) Current Nursing Faculty				
b) Additional Number of Nursing Faculty Needed				
c) Additional Number of Nursing Faculty Needed That Are Funded, But Unfilled				

\* Part-Time status is as determined by the Nursing School/Training Institution.

7. **Source of Funding.**

- a) **Sources of salary and benefits for the Nursing Educator/Instructor** requested are available for the next:

*Select Only One:*

- ☐ One (1) Year                      ☐ Two (2) Years  
☐ Three (3) Years                  ☐ Four (4) Years  
☐ Five (5) Years

**PLEASE TYPE OR PRINT LEGIBLY**

**NOTE: Only Utah Nursing Schools/Training Institutions are Eligible for This Program.**



Utah Department of Health  
Office of Primary Care and Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
Web Site: <http://health.utah.gov/primarycare/>

**UTAH HEALTH CARE WORKFORCE  
FINANCIAL ASSISTANCE PROGRAM**  
**ATTENTION: Nursing Schools/Training Institutions**  
**Site Applications Are Reviewed Twice A Year**

Page 6 of 7

- b) Please include a copy of the **initial type of contract or employment agreement that would be offered to the Nurse Educator/Instructor**. Contracts should include malpractice insurance.
- c) Do you have adequate **sources of financing for staff, administrative personnel, office space, supplies, and equipment** that will be supporting the Nursing Educator/Instructor requested?
- ☐ Yes  
☐ No, please explain: \_\_\_\_\_
- d) Include with site application packet your organizations/agencies written **recruitment and retention plan** that is used to recruit and retain Nurse Educators/Instructors.
8. **Distance to next available school.** If your nursing school/training institution closed, how long would it take your students to reach the next nursing school/training institution where they would be able to obtain their nursing degree(s)? Please identify the name of that school.
9. Person completing this application:
- Name: \_\_\_\_\_
- Title: \_\_\_\_\_
- Email: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_
- X Signature: \_\_\_\_\_ Date: \_\_\_\_\_
10. Additional comments or information: **A maximum limit of 2 pages for any comments or additional information.**

**PLEASE RETURN COMPLETED SITE APPLICATION FORM, AND ATTACHMENTS, TO:**

Office of Primary Care and Rural Health  
Utah Department of Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005

**OR FAX TO:**

(801) 538-6387

**PLEASE TYPE OR PRINT LEGIBLY**

**NOTE: Only Utah Nursing Schools/Training Institutions are Eligible for This Program.**

F:\\_UtahHealthCareWorkforceProgram\HealthCareWorkforceProgram\Applications\Site\HCWF Nurse Educator siteapplication 01-03.wpd 04-14-2004



Utah Department of Health  
Office of Primary Care and Rural Health  
P.O. Box 142005  
Salt Lake City, Utah 84114-2005  
(801) 538-6113 FAX: (801) 538-6387  
Web Site: <http://health.utah.gov/primarycare/>

**UTAH HEALTH CARE WORKFORCE  
FINANCIAL ASSISTANCE PROGRAM**  
**ATTENTION: Nursing Schools/Training Institutions**  
**Site Applications Are Reviewed Twice A Year**

**Page 7 of 7**

### CHECK LIST:

Have you included each of the following? If not, your application may be delayed or denied. *Please assure that each of the boxes below are checked and this Check List is returned with your completed site application.*

- ☐ Have all sections of the Site Application been completed? Sections "not applicable" to the site should have been marked "NA." If not, your site application may be delayed or denied.
- ☐ *Has the Sponsoring Administrative Official of the Site signed on page 1? If not, application will be returned to site.*
- ☐ F.1. Did you provide the Specialty, Education Level, and Setting of the Nursing Educator/Instructor being requested on page 2? If not, application will be returned to site.
- ☐ F.2. Did you include the percent time or FTE of the Nursing Educator/Instructor requested? If not, application will be returned to site.
- ☐ F.3. Did you provide the length of time the Nursing Educator/Instructor vacancy has been unfilled? If not, application will be returned to site.
- ☐ Have you included the Special Qualifications of the requested Nursing Educator/Instructor as listed under section G on Page 3 of application?
- ☐ Have you included the Level of Nursing Students the requested Nursing Educator/Instructor will be training as listed under section H on Page 3 of application? If not, application will be returned to site.
- ☐ Have you included the name of a Nursing Educator/Instructor that you would like matched with your site? This is listed under section H on Page 3 of the application. A response to this question will assist the HCWFAP in matching sites with Nursing Educator/Instructor applicants.
- ☐ 1.a) Did you provide the total number of nursing students enrolled at the nursing school/training institution annually? If not, application will be returned to site.
- ☐ 1.b) Did you provide the number of nursing student applications denied by the nursing school/training institution? If not, application will be returned to site.
- ☐ 1.c) Did you provide the total number of student body at the college/university annually? If not, application will be returned to site.
- ☐ Have you provided the residence of nursing students, as listed under item 2, on page 4? If not, application will be returned to site.
- ☐ 3.a) Did you included a description of the nursing school/training institution as listed in item 3, on page 4? If not, application will be returned to site.
- ☐ 3.b) Did you provide the number of clinical nursing faculty to nursing student ratio and the number of didactic nursing faculty to nursing student ratio as listed under item 3, on page 4? If not, application will be returned to site.
- ☐ Have you responded to question on plans to expand enrollment under item 4 on page 5 of application? This answer is required in order to review your application.
- ☐ Have you included a response to nursing student enrollment diversity under item 5, on page 5?
- ☐ Have you included the current number of nursing faculty and the additional nursing faculty needed for the nursing school/training institution, under item 6, on page 5? This answer is required.
- ☐ 7.a) Did you include the number of years of funding available for the Nursing Educator/Instructor requested, as listed under item 7 on page 5? If not, application will be returned to site.
- ☐ 7.b) Did you include a copy of the initial type of contract or employment agreement that would be offered to the Nursing Educator/Instructor requested? If the Nursing Educator/Instructor will be an employee of the site, a copy of the benefit package that is offered to the employee is requested (i.e., health insurance benefits, hours of paid vacation, hours of sick leave, continuing education leave offered, etc.). If not, application may be delayed or denied.
- ☐ 7.c) Did you respond to adequacy of funding for support staff, office space, etc., as listed under item 7 on page 6? If not, application will be returned to site.
- ☐ 7.d) Did you include a copy of your site's recruitment and retention plan? If not, application may be delayed or denied.
- ☐ Have you responded to item 8 on page 6 of application? If not, application may be delayed or denied.
- ☐ Did you complete item 9 on page 6 and include the signature, email address, and telephone number of the person completing the application?
- ☐ Additional comments or information may include support letters from local community leaders, Nursing Educators/Instructors, or agencies/organizations supporting your recruitment and retention efforts.